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7 August 2010

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Full Marks No. 1 selling head lice brand[2]

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1 [illegible], Brown CM, Lee PN, Pharm Jnl 2008, 280, 371-375 2 IRI Unit Sales 24 w/e 10 July 10

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7 August 2010

Capital gains

C+D showcases pharmacy services to City Hall page 6

CPD ZONE

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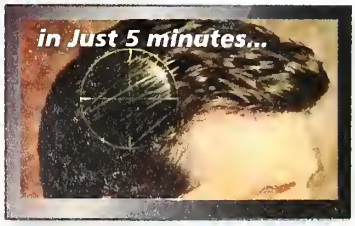

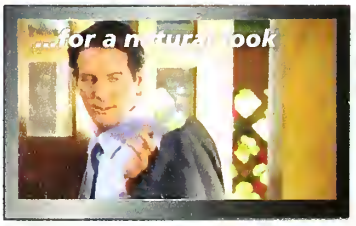

Just For Men, the run-away brand leader, is currently back on TV in all areas... with a brand new campaign throughout August.

Just For Men is the UK's top selling men's hair colorant. And, with a massive £4 million investment in TV Advertising is grooming itself for even greater success this year.

Just For Men is a five minute shampoo-in hair colour that is safe and convenient to use. It targets only the grey without stripping out the hair's natural colour. One application lasts up to 6 weeks without fading or washing out.

Just For Men is also available as a brush-in colour gel specially formulated to penetrate coarse, resistant, facial hair. Its unique non-drip thick gel conditions as it softens. Works in 5 minutes in one easy application to complete a natural look.

So, grey hair beware... **and stand-by for even greater profits for your grooming business this Autumn!**

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> INTERESTINGLY, GPs WRITE AS MANY BITS OF GREEN PAPER AS PHARMACISTS DISPENSE BUT THEY DO NOT GET A SINGLE PENNY FOR THE FP10s THEY ISSUE

This week's news agenda reads like a plot line from Sergio Leone's classic western movie The Good, The Bad and The Ugly.

The Good: Andrew Lansley's statement that he views community pharmacy as an integral part of how GP consortia will deliver services (p7). And the recognition by London Mayor Boris Johnson that pharmacy has so much more to offer than "dispensing prescriptions and selling aspirins" (p6).

The Bad: the furious debate about whether pharmacists will be usurped by machines. Sainsbury's is trialling 'express' prescription vending machines in two stores in Sussex (p6) and opinion is sharply divided over whether the move devalues the role of pharmacists.

The Ugly: the relentless rise in prescription volumes which have now soared an enormous 67 per cent in a decade (p7) and the undeniable knock-on effect this has on workloads and pressures.

Against the context of Andrew Lansley's NHS reforms, which will see a move towards quality outcomes, you have to wonder how pharmacy will ever make the shift from what is still an overwhelmingly volume orientated function when it still can't agree on the value of a vending machine.

So how do we make the shift? The answer isn't necessarily clear cut but, as a starting point, we should consider how the government – the paymaster – views the sector.

Like it or not, pharmacy is an instrument for keeping the prices of drugs down. There is a payment for each 'intervention' (read dispensing fee) and a share of the benefits (read purchase profits). And in reality this mechanism does little to develop professionalism or demonstrate pharmacists' clinical skills. The result is that the average pharmacy is reliant on chasing ever increasing numbers of green paper.

Interestingly, GPs write as many bits of green paper as pharmacists dispense but they do not get a single penny for the FP10s they issue. Instead they are remunerated for the care they provide 'around' each prescription. And this is the difference between the professions.

Quite how pharmacy makes a similar leap is a difficult challenge but not one that is insurmountable. The sector will always have to deal with a volume of dispensing but perhaps this is where automation and technicians come to the fore. And the funding model needs to change so that pharmacists can play their part in the government's new NHS vision.

Allowing (and rewarding) pharmacists to do what they do best – working with their primary care colleagues to help patients get the best out of their medicines – is an opportunity that the NHS cannot afford to ignore. The debate needs to happen and happen now.

Gary Paragpuri, Editor

London mayor backs C+D bid to showcase top pharmacy services

Boris Johnson says London Dossier shows pharmacists go beyond 'dispensing aspirins'

C+D reporters Chris Chapman and Hannah Flynn present the London Dossier to City Hall's Pamela Chesters (left) who said the sector had "all to play for".

Watch London pharmacists describe their innovative services

www.chemistanddruggist.co.uk

Chris Chapman
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Boris Johnson has praised C+D's campaign to highlight pharmacy services across London, and the work pharmacists are doing to deliver healthcare across the capital.

The Mayor of London's comments came as C+D handed over its London Dossier on innovative pharmacy services to City Hall last Friday.

Mr Johnson said: "Pharmacies have an important role to play in serving the needs of the local community. Increasingly the services they offer go beyond dispensing prescriptions and selling aspirins."

"My team is pleased to have received a copy of this dossier which highlights a range of innovative practices which are being developed across the capital," he added.

The dossier, which was designed to highlight pharmacy's increasing role in delivering health services, features six innovative services provided across five PCTs.

Services featured include HPV vaccination, tuberculosis medicines management, minor ailments, oral contraceptives without prescription, smoking cessation and weight management.

Receiving the dossier, the mayor's advisor for health and youth opportunities Pamela Chesters said pharmacists had "all to play for" in taking their place in the future of public healthcare following last month's white paper.

She said: "We want to thank [pharmacists] for the work that they do. Hopefully they will engage fully with the changing landscape."

Pharmacist Cuthbert Chirinda, whose Ridgeway Pharmacy in Southwark was featured in the dossier, said pharmacy could play an increasing role in public health in the future.

He said: "We're capable and well trained people and we can offer a lot of services, taking the weight off GPs so they can offer something else."

See the London Dossier in full in next week's C+D. Watch video interviews on the dossier's featured services, including the view of DH pharmacy tsar Jonathan Mason at **www.chemistanddruggist.co.uk**

Anger at script dispensing machines

C+D readers have reacted angrily to the news that Sainsbury's is to trial "Express Prescription" vending machines at two stores in Sussex.

Readers posting on C+D's website questioned whether the move would really improve access or promote safety.

They said the machines devalued the profession and portrayed pharmacists as "glorified vending machines".

Sainsbury's refuted the criticism and claimed the technology will actually enhance pharmacist roles.

A spokesperson for the supermarket group said: "The machines do not devalue the role of the pharmacist at all."

They added: "They are designed to cater for those patients who wish to collect their medicines without having to wait at the counter, thus freeing up time for colleagues to provide the host of commissioned services the government is looking for."

A team of pharmacists were helping develop the kiosks to ensure they met safety and professional standards, Sainsbury's said.

Professional leaders entered the debate after Neeraj Salwan of Reach Pharmacy posted on C+D's website: "Why have our professional bodies not intervened?"

RPSGB president Steve Churton responded that the machines, with pharmacists still on hand, could offer greater convenience for patients. The NPA said the machines were no substitute for full pharmacy services but could complement them.

Sainsbury's plans to evaluate feedback before rolling the machines out more widely.

The kiosks will be offered at the Haywards Heath and West Green stores alongside Sainsbury's in-store pharmacy.

Sainsbury's says machines will free up time for pharmacists to pursue services

What do you think of vending machines?

Join the debate at C+D's LinkedIn group www.linkedin.com

Superdrug cuts Rx charges

Superdrug has scrapped the mark-u on the cost of medicines dispensed on private prescriptions and halved its minimum dispensing charge.

The multiple this week pledged t be "more transparent" by dispensin all privately prescribed prescription at cost, with a minimum dispensing charge of £2.25 down from £4.50.

Superdrug superintendent Marti Crisp said that the move could save Britons "tens of millions every year

For example, a Superdrug customer will save £9.60 (16 per cent) on 24 anti-malarial Malarone 250/100mg tablets, down from £6 to £50.40.

Mr Crisp said: "We believe that a prescription shows a real need regardless of how or where it was prescribed." For reaction to the move read the full story at www.chemistanddruggist.co.uk

Script volumes climb 67 per cent in a decade

Rises add to increasing workload in the pharmacy, experts warn

Zoe Smeaton
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Total dispensing volumes rose a further 5 per cent in England in 2009, meaning prescription volumes have now increased 67 per cent in a decade.

Experts warned the rises were increasing pressure on pharmacists and said the sector needed to be properly funded to compensate for the extra workload.

Statistics released by the NHS Information Centre show 886 million items were dispensed in the community in 2009. This includes pharmacy, dispensing doctors and appliance contractor dispensing.

In 1999, 530 million items were dispensed. The number of pharmacies has increased by 7 per cent in the last decade.

In 2009 the average net ingredient cost per prescription item was £9.64 – down from £9.99 in 1999.

Pharmacists' Defence Association director John Murphy said increasing workload on pharmacists was "a pressure keg building up".

Mimi Lau, Numark's director of professional and training services, said although a rise in dispensing volumes was no surprise, "What did shock me was the growth in volume against a decade ago."

Ms Lau added: "Dispensing is a core service that pharmacists have to provide and it alarms me that this is often taken for granted by our paymasters."

Earlier this year the C+D and PDA Salary Survey found a third of pharmacists suffering work-related stress levels felt this was starting to affect the service they provided to patients.

PSNC said the contract funding formula took into account changes in dispensing volume.

What was the most dispensed drug in 2009?
We reveal the top five on p8

Pharmacy sales clampdown helps prevent crystal meth epidemic

Pharmacists have helped avert a crystal meth epidemic by championing stricter sales controls on OTC cold and flu remedies, the UK drugs watchdog has said.

A successful clampdown on pseudoephedrine (PSE) and ephedrine (EPH) based drugs had helped keep levels of the class A drug "under control", the MHRA said.

The drugs watchdog ruled pharmacy could continue selling EPH and PSE products after finding no reports of remedies being misused during the past year.

The move comes in marked contrast to an MHRA bid to remove remedies from pharmacies in 2007 over fears lacklustre sales control could spark a crystal meth epidemic.

The proposals were blocked after landslide support for C+D's Stop the Switch campaign, which argued pharmacy could be trusted to regulate the supply of products containing PSE and EPH, and that there was no need to switch them from POM to P.

The MHRA's Committee for Human Medicines noted that the voluntary pharmacy sales measures had been "effective and were much appreciated".

The MHRA praised the efforts of pharmacy representatives to raise awareness among frontline pharmacists.

The RPSGB inspectorate had found one or two instances of unusual quantities of PSE being requested. These were dealt with locally via the Controlled Drug liaison officer or local intelligence network, the MHRA reported.

Sales figures provided by the PAGB show that sales of PSE products declined by 7 per cent from April 2009 to April 2010.

A survey of NPA members conducted in June 2010 revealed that 98 per cent were aware of the rules regarding sales of PSE.

The main supply of crystal meth continues to be import rather than local manufacture, the MHRA concluded. **GA**

MHRA praise vindicates C+D's Stop the Switch campaign which urged the government to let pharmacy police OTC sales abuse

In brief

C+D quizes Lansley

Pharmacists are an "under-used asset" who will play an "integral part" in improving healthcare under the white paper, health secretary Andrew Lansley has told C+D. The comments came in response to a question from C+D editor Gary Paragpuri in a live webchat.

New service looms

A service where pharmacists offer additional support to patients newly prescribed a medicine for a long-term condition looks set to be agreed, PSNC chief executive Sue Sharpe has said. The service was currently under negotiation between PSNC and NHS Employers, Mrs Sharpe said.

Homeopathy on NHS

Homeopathy will continue to be available on the NHS if backed by local clinicians. The decision was revealed in a government response to a House of Commons evidence check on the alternative therapy, which found it was no more effective than placebo.

Drug Tariff changes

Gedarel 20mcg/150mcg and 20mcg/150mcg, Millinette 20mcg/75mcg and 30mcg/75mcg, Rigevidon and TriRegol tablets have been added to the list of contraceptive products to be dispensed free of charge. The change comes into force from the August edition of the Drug Tariff.

Dispensing errors

The latest guidance on the prosecution of dispensing errors is only a "stop gap", the pharmacy minister has said. Earl Howe told the all-party pharmacy group more comprehensive protection was currently under discussion at the group's summer reception.

Lloyds pre-reg award

Tim Brown has been named Lloydspharmacy's pre-registration graduate of the year. Mr Brown works at the multiple's Fenton Road pharmacy in Rotherham, South Yorkshire.

More In Brief online
www.chemistanddruggist.co.uk

Lost disciplinary days

The RPSGB disciplinary committee lost six hearing days following the recent resignation of two chairmen, last month's GPhC council meeting heard. The days will be made up in October and November, the GPhC said.

An inspector calls

All community pharmacies in England will receive a CD monitoring visit by December 31, the GPhC has said. Scottish pharmacies can expect the inspectorate by September.

Pharmacy goes all 1940s

Pharmacy chain Stewart Pharmacy's relocated Bengeworth Pharmacy has been given a 1940s style makeover. The pharmacy is modelled on pharmacist David Badham's original 1940 business. See the pictures at **www.chemistanddruggist.co.uk**

Ramadan MUR service

The Co-operative Pharmacy has announced it is extending its Ramadan MUR service to 82 pharmacies. The multiple will offer stop smoking advice alongside guidance on taking medicines correctly during the fasting period. **www.chemistanddruggist.co.uk**

Ask Your Pharmacist

The NPA's Ask Your Pharmacist Week starts on November 8 and will focus on the role pharmacy plays in communities and as a frontline healthcare provider. **www.chemistanddruggist.co.uk**

PSNI legal guidance

Pharmaceutical Society of Northern Ireland officials have launched an updated guide to legal requirements on pharmacists in the province. It provides a reference on legislation applying to the sale or supply of medicinal products, poisons and chemicals.

Simvastatin is England's most prescribed drug

Top five drugs are 12 per cent of volume but only 2 per cent of cost

Chris Chapman
chris.chapman@ubm.com

Cardiovascular drugs are the most commonly prescribed medicines in England, with four of the top five drugs dispensed last year used to treat cardiovascular disease (CVD), the NHS has revealed.

Simvastatin, ramipril, aspirin and bendroflumethiazide accounted for more than 109 million of the 886m items dispensed in 2009, according to the NHS Information Centre.

However, despite equating to 12 per cent of prescription volume, the drugs made up less than 2 per cent of the £8.5 billion NHS drugs bill.

Rounding out the top five was levothyroxine, with almost 22 million items dispensed.

The most expensive BNF category by ingredient cost was drugs used in diabetes (chapter 6.1), with the 35.5m items dispensed costing the NHS £634m in 2009 – a rise of more than 40 per cent in the past five years. However, prevalence of diabetes in England had increased from 3.3 per cent to only 4.1 per cent of the population in the same period.

The average ingredient cost per item fell 24p compared with 2008 to £9.64. Two-thirds of medicines dispensed were generics, although these represented only 28 per cent of the total medicines spend.

For further analysis, see **www.chemistanddruggist.co.uk**

Top five drugs by items dispensed

- Simvastatin: 37.3m
- Aspirin: 33.9m
- Levothyroxine: 21.9m
- Ramipril: 19.3m
- Bendroflumethiazide: 18.8m

Clinical debate — C+D's Chris Chapman looks at the evidence behind the headlines

Why diabetes MURs are a must

Diabetes is recognised as one of the most significant health problems of the 21st century, with around 4.1 per cent of the population in England affected. If you believe warnings of an impending obesity epidemic, this number could double by 2020. For pharmacists, however, several recent developments in diabetes will come in to play much sooner.

The first is the withdrawal of Mixtard 30 by Novo Nordisk, set for the end of the year. According to charity Diabetes UK, this will affect around 90,000 patients currently prescribed the insulin, who will need to move to alternatives.

Next comes the debate over rosiglitazone. Two recent papers (see www.chemistanddruggist.co.uk) have sparked further concerns over cardiovascular risk. European watchdog the EMEA is currently reviewing the use of rosiglitazone, instructing prescribers "to strictly follow the current restrictions in the product information".

Thirdly, the latest stats from the NHS Information Centre show the net bill for diabetes drugs is up 42 per cent in the past five years – mainly due to newer treatments. Diabetes drugs now cost the NHS £634 million a year, with much of this is down to glucose testing strips (£145.8 million) and human analogue insulins (£255 million).

In an NHS demanding cost-effective, public health interventions, the part that pharmacists have to play is obvious.

MURs for patients with diabetes have always been important, helping them not only control their blood glucose but also manage a host of medicines, both for diabetes and co-morbidities. With the recent developments, the significance of the role has only increased.

To discuss this subject in private with your pharmacy colleagues, join the debate in C+D's Linkedin group at www.linkedin.com – search for Chemist and Druggist.

Chat with Chris on Twitter: www.twitter.com/CandDChris

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GPhC chief on future plans for regulator
www.chemistanddruggist.co.uk/news

Dispensary talk

Has the minor ailments service been scrapped in your area?

"It was scrapped in March this year. It was very successful and we even had patients petition Dudley PCT to stop the service being ended."
Pradeep Prabhu, Murrays Healthcare, Halesowen, West Midlands

"Ours hasn't been scrapped yet, but I am aware it is being talked about at the moment."
Ravi Vaitha, Kamsons Pharmacy, Crawley, West Sussex

Web verdict

Yes 38%

No 62%

Armchair view: Over a third of respondents report the minor ailments service has been scrapped by their local PCT, illustrating significant cuts to the sector.
Next week's question:
Are automated dispensing machines good or bad for pharmacy? Vote at **www.chemistanddruggist.co.uk**

RPSGB faces review over complaints waiting list

Society insists cases 'undertaken thoroughly' in response to criticism

Chris Chapman
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The government has tasked regulatory watchdog The Council for Healthcare Regulatory Excellence (CHRE) to review the speed of the RPSGB's regulatory procedures, following concerns in a House of Commons report.

In its response last week to the House of Commons Science and Technology Committee's evidence check on homeopathy, the government said it would instruct CHRE to review the Society's "handling of complaints in terms of both thoroughness and timeliness".

The move follows comments in the Science and Technology Committee report, published in February, which expressed concern about the length of RPSGB investigations. The report urged the government to enquire whether the RPSGB "is doing an adequate job in respect of time taken to pursue complaints".

Some cases have taken over five years to reach hearing at RPSGB's Lambeth HQ

Responding to the government's statement, the Society accepted its complaints process "can appear lengthy", but insisted investigations were "undertaken thoroughly".

However, Charles Russell solicitor Noel Wardle said some of his cases had taken five or six years to be listed, and there was now a "serious backlog".

"It's not the appearance of a delay, it's an actual delay," he insisted.

Some of the delay is built into current RPSGB procedures, and may be removed when the General Pharmaceutical Council takes over regulation in September, Mr Wardle added.

The Society was committed to ensuing all existing fitness to practise cases are progressed "to the best of our ability" before handover to the GPhC, an RPSGB spokesperson added.

GPhC issues council funding alert

Further delays to the launch of the General Pharmaceutical Council (GPhC) could exhaust a £4.4 million start up grant for the new pharmacy regulator's council.

Balance sheets presented at last month's council meeting forecast a £427,830 cash loss between June and September this year.

The council will start eating into working capital reserves from next month, warned GPhC finance chief Bernard Kelly.

The organisation is reliant on revenue from regulatory activities, but can't secure funding until it officially takes over powers from the RPSGB.

The transfer is scheduled for late September, but has already been delayed from April this year.

Further hold ups presented financial dangers, Mr Kelly stressed.

A written paper by the GPhC's director of resources said: "That would require the council to rely upon the working capital grant for day to day funding rather than use those funds for investment in premises and equipment development projects."

The GPhC has netted over £4m in government aid since establishing in shadow form this March, Mr Kelly added. This includes a £2.4m working capital grant and £340,000 for start up costs.

See the full balance sheet at www.chemistanddruggist.co.uk **MG**

YOU UNDERSTAND WHAT SUFFERERS ARE GOING THROUGH

SO DOES THIS

A new advertising campaign backed by a six-figure media spend will mean more women asking for Cymalon.
Make sure you recommend the brand that understands what sufferers are going through.

Ensure you're fully stocked-up today and ready to talk to your customers about Cymalon.

For further information about Cymalon, visit www.cymalon.co.uk.

actavis
creating value in pharmaceuticals

Actavis commits to OTC with investment in two brands

Actavis has indicated its commitment to growing OTC markets, with investment in two of its 17 brands.

The manufacturer, better known for its generics business, last week announced advertising campaigns for sleep aid Sominex and cystitis brand Cymalon.

"We want to really realise the true potential of OTC in the UK," said Actavis OTC director Richard Hollies. "We are committed to pharmacy."

Actavis's POM to P pipeline is "very strong", Mr Hollies added, predicting more switches "over the next few years" to follow its launch of azithromycin brand Clamelle in 2008.

Market focus

SLEEP AID

- The sleep aid market is worth £29.2 million.
- Herbal sleep aids have a growing 35 per cent share of the market.

CYSTITIS

- The cystitis market is worth £4.7 million.
- Pharmacy has a 69 per cent share of the cystitis market.

Source: IRI, HBA outlets, 52 weeks to May 15, 2010

£2m support for Sominex

Actavis has this week launched a £2 million advertising campaign and packaging update for sleep aid Sominex.

The brand makes its TV debut in adverts that tell viewers they no longer need to rely on counting sheep to get themselves to sleep.

Testing shows the TV adverts, which will run throughout August, have "real memorability", said Actavis OTC marketing manager Angela Lloyd.

Supporting press advertising, which will run until the end of November, means that over 90 per cent of the target audience will see campaign activity on average seven times.

The campaign will also be supported by consumer PR activity and POS material, and the manufacturer predicts it will significantly grow the brand's 4 per cent share of the sleep aid market.

"We have a huge amount of investment to put behind this, which will grow the brand to double-digit share," Ms Lloyd said.

Prices: **£3.15/8; £4.79/16**
Pip codes: **014-5318; 323-4663**
Actavis
Tel: 0800 373 573
www.sominex-sleep.co.uk

Cymalon given a £250K digital boost

Actavis is investing over £250,000 in a digital and social media campaign for cystitis brand Cymalon that will run until November.

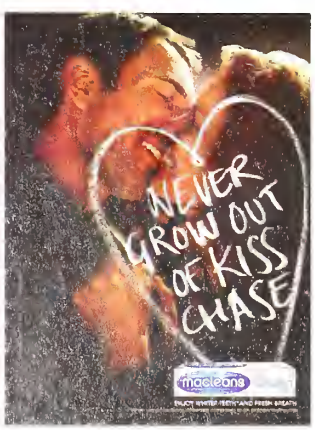
A Facebook-hosted competition is aimed at establishing Cymalon as "the product that understands how women feel", by comparing the lack of understanding men have when buying gifts to their absence of knowledge about cystitis.

Consumers are invited to reveal the worst gift they have ever received for an opportunity to win an iPad or iTunes vouchers.

The Really Rubbish Gifts competition will be supported by adverts on "female-oriented" sites, including Cosmopolitan, Net Doctor and Yahoo Mail.

Pip codes: **022-5607; 304-2652; 346-6364**
Actavis
Tel: 0800 373 573
www.cymalon.co.uk
Prices: **£4.45/6 Cymalon Sachets; £4.45/60ml Cymalon Liquid; £4.95/60 Cymalon Cranberry Extract**

GSK extends Macleans Whitening campaign



GSK Consumer Healthcare is extending its summer press campaign for Macleans Whitening toothpaste into August.

The move is part of an £840,000 summer boost for the brand, which has been the focus of an advertising campaign throughout June and July this year.

Based around the idea of 'enjoying whiter teeth and fresh breath', the campaign features two couples kissing or about to kiss.

The campaign will continue in 15 women's monthly magazines and 16 weeklies including Sunday supplements, GSK adds.

Price: **£3.55/100ml**
Pip code: 343-8686
GSK Consumer Healthcare
Tel: 0845 762 6637
www.mypharmassist.co.uk

Check out what's on TV this week

www.chemistanddruggist.co.uk/prodnews

Arnicare range expanded

Nelsons has added arnica bath and massage balm to its Arnicare range.

The product can be used as a massage product and can be added to a bath.

A spokesperson says the product will be targeted at existing Arnicare customers, and added that the Arnicare brand has grown an average of 9 per cent year-on-year for the past three years.

Price: **£7.95/200ml**
Pip codes: **356-3400**
Nelsons
Tel: 0800 289 515

Non-slip stick tip launched

Flexyfoot has announced the launch of a rubber tip replacement for walking sticks and Zimmer frames.

The shock-absorbing, anti-slip Flexyfoot is designed to replace the old fashioned rubber tips on these walking aids, and offers up to 50 per cent more grip on floors, according to the company.

The product is patented and can rotate by 360 degrees, meaning the walking aids can be turned easily, adds the manufacturer.

It is available in four different sizes, and replacement feet can be ordered.

Price: **£12.99**
Pip codes: **See C+D Monthly Price List or www.cddata.co.uk**
Flexyfoot
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New licensed liquid Simvastatin. A heartfelt solution for patients who can't swallow tablets.

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One common problem is difficulty with swallowing,[1] so Rosemont have launched the only licensed liquid Simvastatin as an easy to swallow alternative. Pleasant tasting and in a choice of strengths it is a welcome solution for patients who are unable to swallow tablets.

Abbreviated Prescribing Information: SIMVASTATIN [illegible] **Oral Suspension.** Consult Summary of Product Characteristics before prescribing. **Presentation:** [illegible] **Therapeutic indications:** [illegible] **Posology and Method of Administration:** [illegible] **Interactions:** [illegible] **Pregnancy and lactation:** [illegible] **Effects on ability to drive and use machines:** [illegible] **Undesirable Effects:** [illegible] **Overdose:** [illegible] **Shelf Life and storage:** [illegible] **Pack Size and NHS Price:** [illegible] **Marketing Authorisation Holder:** [illegible] **Marketing Authorisation Number:** [illegible] **Date of Preparation:** [illegible]

References: [illegible]

Rosemont

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Information about adverse event reporting can be found at www.yellowcard.gov.uk Adverse events should also be reported to Rosemont Pharmaceuticals Ltd on 0113 244 1400.

Complete the IT Zone Survey online at: **www.chemistanddruggist.co.uk**

IT Zone Survey

Is IT helping you to do your job properly or just causing you more headaches? Complete the survey by August 27 and look out for the results when the IT Zone, supported by AAH, launches in September

[illegible]

a) EPoS system ❑
b) EPS compliant IT system ❑
c) Internet access ❑
d) Other (please specify) ❑

.....

[illegible]

a) Yes ❑
b) Not significantly ❑
c) No ❑

[illegible]

a) Lack of training ❑
b) PMR system incapable of doing more ❑
c) Cost ❑
d) Time ❑
e) Can't see benefits ❑

[illegible]

Please specify
.....
.....
.....
.....
.....
.....
.....

5. What one thing would you like to see your PMR system doing?

a) Providing detailed data on patients so I can target services ❑
b) Enabling better recording of interventions ❑
c) Providing better support for clinical services ❑
d) Providing better integration into NHS ❑
e) Speeding up MUR admin ❑
f) Other (please specify)

.....

6. How many prescriptions do you process using EPS Release 1 (or equivalent if not in England) on average per month?

Please specify
.....
.....

7. What is the average download time of prescriptions processed electronically?

a) Less than a minute ❑
b) 1 minute to 5 minutes ❑
c) 5 minutes to 20 minutes ❑
d) More than 20 minutes ❑

8. Overall do you think EPS is a good thing for pharmacy?

a) Yes ❑
b) No ❑
c) Unsure ❑

9. How concerned are you about the introduction of paperless prescription systems and what might happen if systems go down?

a) Very concerned ❑
b) A little concerned ❑
c) Not concerned ❑

10. Do you back the government's summary care records programme?

a) Yes ❑
b) No ❑
c) Not sure ❑

11. How would you feel about accessing patient data from a secure source outside the pharmacy?

a) Nervous about confidentiality ❑
b) Happy to try it ❑
c) Pleased – it saves us keeping the data confidentially ❑

12. How much have you spent on IT in your pharmacy over the last three years to the nearest £500?

Please specify
.....

How much of this was NHS funded?

Please specify
.....

The IT Zone, supported by AAH, will be a one stop shop for pharmacists on IT, featuring expert comment, industry insight, FAQs and more. Access it via C+D's website from September 18.

the IT ZONE

Supported by AAH

Your name: _____

Pharmacy name and address: _____

Postcode: _____

Email address: _____ **Daytime phone number:** _____

Post this completed page to: **IT Zone Survey, C+D, Ludgate House, 245 Blackfriars Road, London SE1 9UY.**

All complete entries received by August 27 will be put into a draw for a chance to win an iPod Touch.

Please tick if you would like to receive: **C+D Daily News Alert** ❑ **C+D Saturday Review** ❑ **C+D CPD Bulletin** ❑

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The Finance Zone

PART 7: Budgeting for locums. Richard Baker explains what you need to consider

For many, the life of the locum provides a number of advantages – the main one being flexible working arrangements.

One of the main disadvantages of being a locum is the administration that goes with being self-employed. It is manageable, however, as long as you are organised. Keep your receipts for expenses together and keep a full, detailed record of your income by 'customer' – ie, the pharmacy you work for.

Richard Baker: being organised is the key to successful self-employment

Employed or self-employed?

From a tax point of view, one of the main issues for locum pharmacists (and their 'customers') is whether they are actually self-employed or not. This may seem strange but if, as a locum, you take on some or all of the range of duties of an employed pharmacist – which may include general supervision of staff, cashing up, re-ordering of non-pharmacy stock and so on – you may be classified as 'employed', meaning that your 'employer' would need to pay you after the deduction of PAYE and National Insurance.

The key difference for the 'employer' is that they would suffer employer's National Insurance contributions on your remuneration. There are locum contracts available that set out suitable terms but it is the reality of the situation, rather than the contract terms, which is of paramount importance.

Business structure

Another issue to consider is how you will operate your business. The two main choices are as a sole trader or through a limited company. The administration of a sole trader business is easier (and less expensive) but it is generally more tax efficient to run your business through a limited company.

Generally

If you are thinking about self-employment you need to consider:

- Holidays – in particular, the timing of them and ensuring that you save enough to pay the bills when you are not working.
- Illness or incapacity and how you would cope – consider insuring yourself against this risk.
- Income tax bills – putting some of your income aside on a regular basis to pay tax.

Key points

- Keep a full income record by 'customer'.
- Keep expenses receipts organised and together.
- Make sure you know whether you are classified as self-employed or an employee.
- For self-employed operations, consider whether you want to operate as a sole trader or a limited company.
- Other budgeting issues to consider are holidays, illness and income tax.

Richard Baker is a partner at accountancy firm Horwath Clark Whitehill

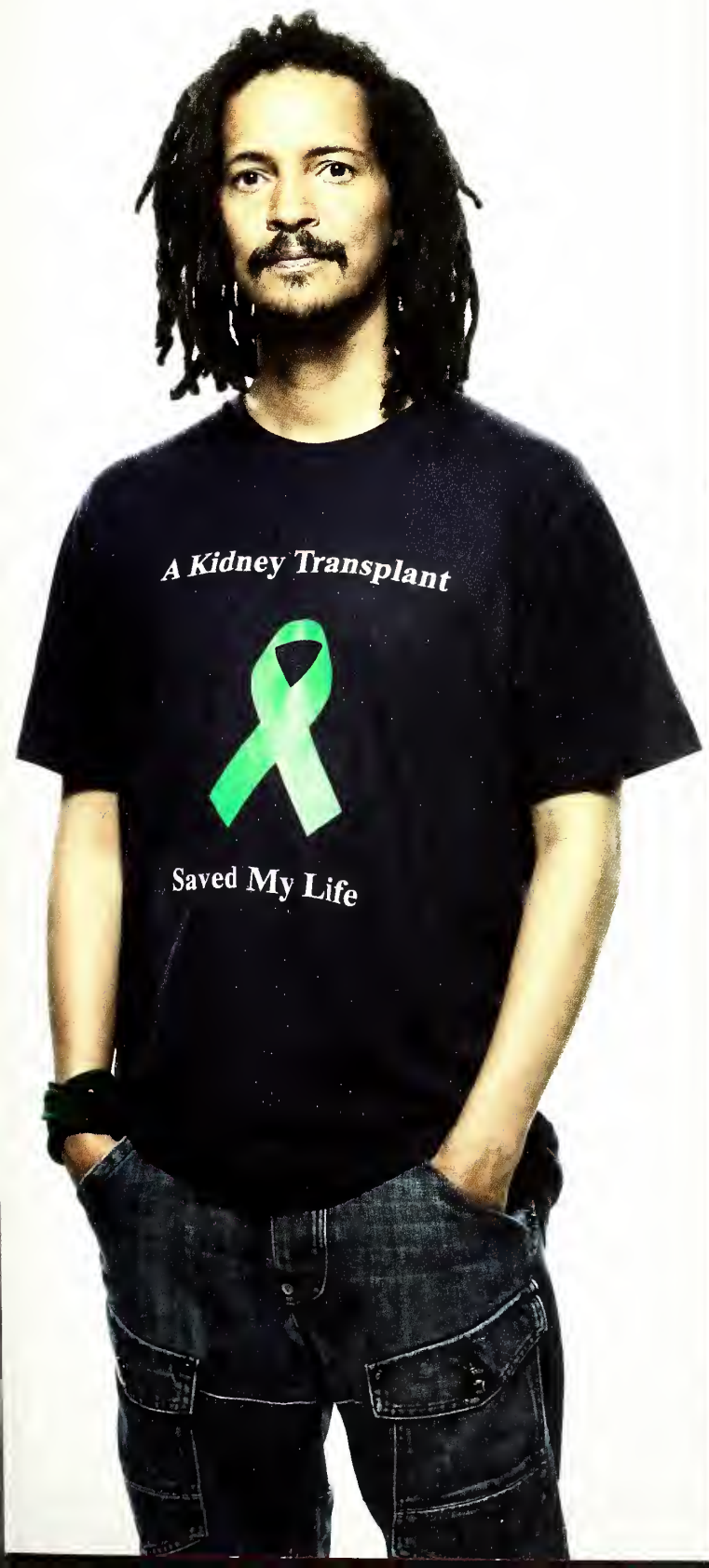
Horwath Clark Whitehill

NEXT MONTH

When to expand – and raising the finance

References

* NHS Blood and Transplant, August 2009. NHS Transplant Activity in the UK, 2008–2009
† www.kidney.org.uk June 2010.



I was one of 7190 people waiting for a kidney*

5 years waiting†

12 hours of dialysis a week†

780 hospital visits†

1 car crash 3 families affected

2 ambulances 3 doctors 4 nurses

1 specialist transplant team

1 organ donor 1 life-changing gift

1 personalised drug regimen

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Prescribing information can be found on the adjacent page

Job code: PRG10028UK Date of preparation: June 2010

Ditch the data overload for peace of mind

"THROW AWAY THOSE FETTERS OF FACTS AND FREE YOURSELF WITH A WASTE BIN AND THE DELETE BUTTON"

You have a week off, and your first day back is always the same – a queue of staff with problems, a pile of post to open, and your locum's bill to pay. Only the last few years have also brought another treat in store – the 200 unread email messages.

Of course it's easy enough to delete the spam, the joke or video links that would contravene any company's diversity policy, and the Facebook invites from friends who need to get a life, but that still leaves the ever increasing 'professional' emails. The NPCi blog updates, the NPA and PLB news, and emails from the PCT about the opportunity to sign up for yet another LES...

Maybe it's just me, but I certainly don't remember opting in for all of these emails. Now we are assumed to need an electronic newsletter on a seemingly daily basis telling us about the crawl towards ennoblement of the GPhC, that our new CEO Nurse Helen is a 'people's person', and that our vice-president is appearing in pantomime on BBC2.

'Information overload' is nothing new – it's just changed from letters and memos to emails and websites – and were I a better man I would hit 'delete' to all of these, except that I know somewhere in the morass is some important information. Our professional life is spent ensuring we have the right facts and knowledge, so we fear missing something – even our CPD site is called 'Up to date', emphasising what a crime it is to be left behind. The problem is that it's five minutes to read the message, another 10 to read the linked webpage, and then maybe another 30 minutes to write the newly required SOP or prepare the updated staff training, and that's before I've caught up with the C+D, and PJ, and the box of post left by the locum... So I tell Mrs Xrayser I'm going to be home late again, and realise too late I should have asked her to record Top Gear.

So if like me your email quota is maxed out and you sit beside an ever increasing pile of papers, letters and guidance, then it's time for radical pruning. It's not going to stop us feeling guilty for leaving each magazine in its wrapper and ignoring those emails, but sometimes you have to bite the bullet and accept that you're never going to read it. So courage mon brave! Throw away those fetters of facts, ditch the deadweight of data, and free yourself with a waste bin and the delete button. Now – doesn't that feel good! Just think how much more productive you'll be – at least until the pile builds up again and we start receiving Facebook invites from Nurse Helen.

Is increasing bureaucracy a necessity of modern life?

haveyoursay@chemistanddruggist.co.uk

Professional ambitions come with a price tag

It's an interesting time to be a new regulatory body. Public and private finances are under pressure on all fronts. The case for regulation needs to be set out clearly, so that those who are asked to pay the price for regulation also have the chance to appreciate its value.

Survey after survey validates our day to day experience that patients, and the public generally, have a high level of trust in health professionals, including professionals in pharmacy. I'm sure that neither patients nor professionals will want or appreciate regulation which gets in the way, in an officious or bureaucratic fashion.

We're not here to second guess your professional expertise and judgements, or to try to come between you and those you serve. Both patients and professionals do however rely on a number of key assumptions, which we regulatory types have a duty to make good on, for everyone's sake. The assumption is that the people providing expert professional services know what they are doing and that they are people with a commitment to standards which goes beyond their contractual, commercial or legal obligations, taking in an ethical dimension which is about caring for patients and putting them first.

The assumption is also made that if there is a problem there's a fair way of looking into it, and that those who are in the wrong occupation (of which there are a few in all walks of life) will be identified.

The regulator has a key role in making sure that these assumptions are valid. There must be entry standards for the profession and a system to make sure standards are being maintained. There needs to be a database of the people who meet the standards. We need some standards for them to work to, and a fair process for identifying and resolving doubts about the continuing suitability of a few.

So when that letter arrives in a few weeks asking for money to fund regulation, and asking you to make an updated declaration of your continuing fitness to practise and you wonder "What am I getting for my money?", you might imagine what it would be like to work in a parallel unregulated pharmacy universe in which the only principle was 'Buyer beware!' With no standards, no validated list of qualified colleagues and no ethical framework underpinned by fair and proportionate processes, what kind of 'profession' would that be?

Fulfilling these ambitions comes at a price. We believe what we have proposed is fair but remember, the price we would all pay for failure would be much higher!

Duncan Rudkin is chief executive and registrar of the GPhC

Will handing regulation to the GPhC be good for pharmacy?

haveyoursay@chemistanddruggist.co.uk

"IMAGINE WHAT IT WOULD BE LIKE TO WORK IN A PARALLEL UNREGULATED PHARMACY UNIVERSE IN WHICH THE ONLY PRINCIPLE WAS 'BUYER BEWARE!'"

Guide to Diabetes and oral health

Pharmacy teams can provide their diabetic customers with a more comprehensive level of care by offering appropriate oral care advice to help them maintain a healthy mouth

Colgate


Colgate
Total
Long Lasting Anti-bacterial Protection
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Total
Long Lasting Anti-bacterial Protection
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Guide to Diabetes and oral health

Sustained elevation of blood (sugar) glucose is associated with damage to various organs particularly the eyes, kidneys, heart nerves and blood vessels. There is also evidence that patients with diabetes, particularly those who are poorly controlled, are more at risk of destructive periodontal disease (periodontitis) and may not respond well to its treatment.

Oral complications of diabetes

Whilst the oral complications may appear to be insignificant when compared to other more serious complications, there is good evidence that diabetics, particularly those poorly controlled, are more likely to develop destruction of their periodontal tissues including:

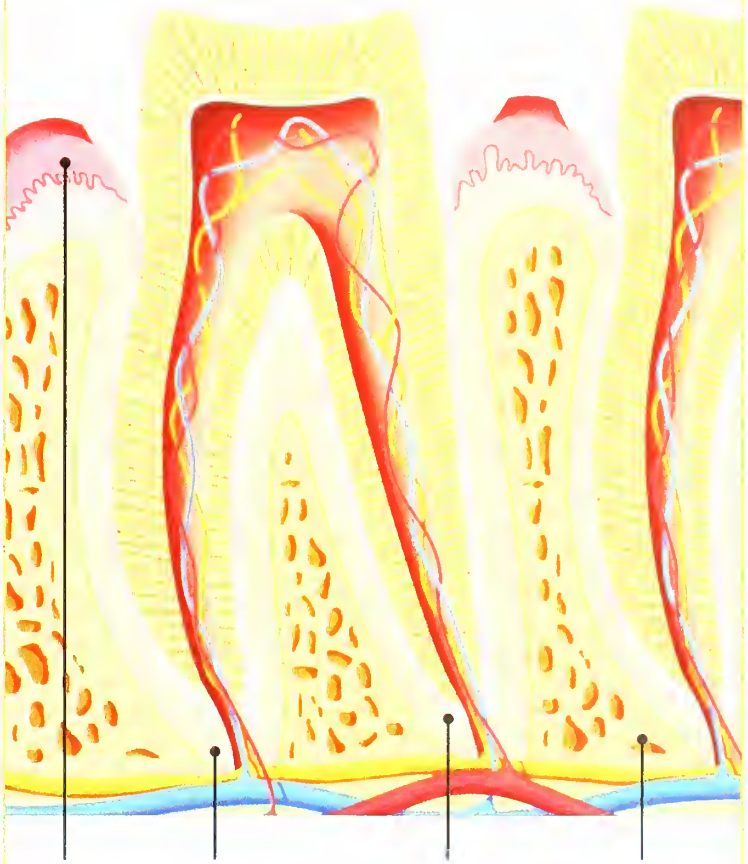
- Increased incidence and severity of periodontal disease
- Xerostomia (dry mouth)
- Infections (fungal/candidiasis)
- Poor healing
- Burning mouth syndrome
- Recurrent ulcerations
- Oral neuropathies (tingling, pain, numbness).

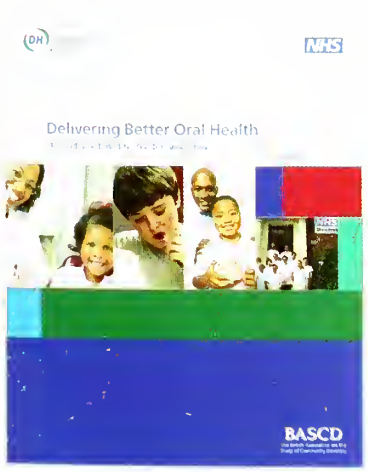
Periodontal tissues

Periodontal tissues comprise: gingiva – surrounding teeth, periodontal ligament – suspending teeth from bony socket, cementum – covering tooth root surface, and alveolar bone –anchoring tooth via collagen fibres. They function as a unit that:

- attaches the teeth to the jaw bones
- protects the teeth from chewing forces
- and therefore, facilitate normal oral function.

Structure of tooth and periodontal tissue





Improving Periodontal Health – The Prevention Toolkit

The recently published consensus on evidence based advice for improving periodontal health focuses on the role of daily oral health hygiene.[1]

The following advice and support should be given to patients presenting with or at risk of periodontal disease:

- Teeth should be brushed twice daily. Recommend to modify the existing method of brushing, emphasising the need to systematically clean all tooth surfaces.
- Disclosing tablets can help to indicate areas that are being missed.
- Help the patient to select a small headed toothbrush with soft, round ended filaments, a compact, angled arrangement of long and short handle that is comfortable for them to use.
- Powered brushes with an oscillating / rotating action may be advised.
- For interdental cleaning, the choice of aid (floss, tape, sticks, single tufted brush) should be based on the size of the interproximal spaces and the ability and motivation of the individual.

The Department of Health Recommendation – Toothpaste and Mouthrinse

Toothpaste

'Delivering Better Oral Health – An evidence-based toolkit for prevention'[1] states that evidence suggests toothpastes containing triclosan in combination with a copolymer or with zinc citrate are more effective than a fluoride toothpaste in improving plaque control and gingival health.

Colgate Total toothpaste

Colgate Total toothpaste for everyday use contains a unique combination of triclosan and copolymer, to provide 12-hour antibacterial activity.[2]

How does Colgate Total work?

Daily toothbrushing removes plaque bacteria mechanically. However plaque bacteria immediately starts to reform (see Figure 1, below).

Colgate Total's unique triclosan and copolymer formulation enables retention of triclosan on teeth and gums, preventing dental plaque from reforming for up to 12 hours[2] (see Figure 2, below) providing:

- Up to 98% plaque reduction[4]
- Up to 88% reduction in gingival (gum) bleeding[3]

Figure 1

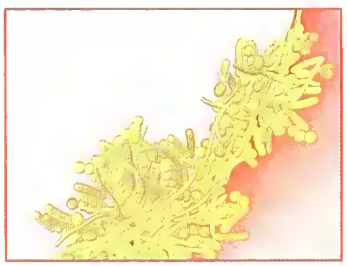
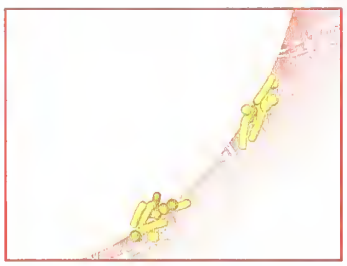


Figure 2



(Graphical representation, for illustration only).

Colgate Total toothpaste is clinically proven to reduce the progression of periodontitis.[4] Additionally Colgate Total contains 1450ppm sodium fluoride, recommended as optimal for caries prevention in adults.[1]

Mouthrinses

'Delivering Better Oral Health – An evidence-based toolkit for prevention'[1] states that chlorhexidine mouthrinses containing 10 ml of 0.2% chlorhexidine are very effective in improving plaque control and gingival health when used as an adjunct to tooth brushing. They are useful for short periods when an individual is unable to clean due to acute problems or incapacity.

Colgate Periogard 0.2% Oromucosal Solution

Colgate Periogard is an alcohol-free chlorhexidine digluconate mouthrinse for home treatment. Chlorhexidine digluconate interacts with the bacterial cell wall, inhibiting dental plaque. Colgate Periogard has the following product benefits:

- Clinically proven to inhibit plaque re-growth[5]
- Clinically proven to inhibit gingivitis[5]
- Suitable for patients who may prefer an alcohol-free mouthrinse

Colgate

For further information please call the Colgate Customer Care line on 01483 401901 or visit www.colgatepharmacy.co.uk

References:
1. Delivering Better Oral Health – An evidence-based prevention toolkit, 2009 **2.** Armonchat C et al. (2004), Dent J; 24; 103-111 **3.** Garcia-Godoy F et al.(1990), AM J Dent;3(spec Issue):S15-26 **4.** Rosling B et al. (1997) J Periodontal;24:873-880 **5.** Lorenz K et al.(2006) J Clin Periodontol; 33:561-67

Update

Your weekly CPD revision guide

60-second summary

This article, which can be used as part of CPD, explains the purpose of TDM in transplant patients and autoimmune disease, HIV infection, cancer and rheumatoid arthritis.

When do patients receiving ciclosporin require monitoring?

Ciclosporin's pharmacokinetics and metabolism vary widely in different patients, but TDM is used in early treatment only – continuing routine monitoring is not considered necessary.

What is the role of TDM in HIV treatment?

Multiple agents are typically used together in HIV. TDM is used to adjust doses to achieve targeted concentration ranges, often in conjunction with HIV resistance tests. Inadequate concentrations resulting from poor adherence can result in the virus evolving mutations that may limit drug choice.

Why isn't TDM used widely in cancer treatment?

TDM is not routinely used in cancer treatment because there is no established relationship between drug concentration and treatment effect. Also, with anti-cancer medicines that target enzymes, it is easier to monitor the enzyme in question than to use TDM.

Therapeutic drug monitoring: part 3

The third article on TDM covers immunosuppressants, HIV, anti-cancer drugs and DMARDs

Ravina Tasgaonkar MRPharmS

This article looks at therapeutic drug monitoring (TDM) of immunosuppressant, human immunodeficiency virus (HIV) and anti-cancer or disease-modifying antirheumatic drugs (DMARDs).

As these conditions are not regularly assessed by community pharmacists, this article takes a clinical look at treatment and can help prepare for a seamless handover in situations where a dispensing service is needed.

Immunosuppressant drugs

Immunosuppressants are normally used to damp down the immune response in transplant patients to prevent the body from rejecting the implanted organ. They can also be used in autoimmune disorders such as severe psoriasis, atopic dermatitis and rheumatoid arthritis.[1]

Ciclosporin Ciclosporin is mainly used in transplant patients to prevent organ rejection. The various brands and formulations have different bioavailabilities, and are not interchangeable, except in the case of capsules and oral solution, which are bioequivalent.

TDM is only used when initiating and optimising a patient's immunosuppressive regimen at the start of treatment, and routine monitoring is unnecessary.

Ciclosporin is the most widely studied immunosuppressant, yet the optimum strategy for monitoring is controversial. Owing to its widely variable pharmacokinetics and metabolism, and the absence of a simple method to measure therapeutic effectiveness, many factors should be considered in adjusting therapy.

In most patients, measuring whole blood through concentrations of ciclosporin with a specific assay methodology is warranted.

For maintenance, dosage must be individually titrated to the lowest effective level, and should not exceed 5mg/kg given orally in two divided doses.

Ciclosporin is a calcineurin inhibitor that prevents the activation of T cells and expression of interleukin 2 (IL-2), which also stimulates the growth and differentiation of T cell response.

It appears to work by blocking the resting lymphocytes in the G_0 or early G_1 phase of the cell cycle, and also inhibits lymphokine production and release, including IL-2. Ciclosporin acts specifically and reversibly on lymphocytes.

In the liver, ciclosporin also inhibits P450 (CYP3A4) and elsewhere in the body it inhibits the multidrug efflux transporter P-glycoprotein. This may cause interactions with other medicines.

Pharmacokinetic properties Ciclosporin has no single major metabolic pathway and is extensively biotransformed to approximately 15 metabolites. Elimination is primarily biliary.

The half-life ranges from 6.3 hours in healthy volunteers to 20.4 hours in patients with severe liver disease.

The widely used Neoral formulation provides a consistent absorption profile and exhibits high bioavailability. For side effects, contraindications and interactions, see the SPC.[1]

HIV

HIV infects and then destroys CD4 cells that are responsible for fighting infection. Although the body attempts to produce more CD4 cells, their numbers will eventually decline and the immune system will stop working, which puts the sufferer at high risk of developing a serious infection or other disease, such as cancer. Acquired immune deficiency syndrome (AIDS) is used to describe the latter stages of HIV, when the immune system has stopped working and the person develops life-threatening conditions such as pneumonia.[2]

In the UK, rates of sexually transmitted infections (STIs) are increasing in all age groups, but over 36 per cent of all new cases of HIV in the UK are in the 35-44 age group. This compares to just 7 per cent in the under-25 age group.

To combat these infections, the government has drawn up a national strategy for sexual health and HIV, and a supporting action plan.

There is stigma attached to HIV that prevents some patients from seeking medical assistance, and services need to be confidential, supportive and relevant. The Independent Advisory Group in 2004 asked the government to consider the role that community-based organisations such as

pharmacies can play in the diagnosis and support for people with HIV; it also asked for sexual health and HIV to be included in the National Service Framework (NSF) – however, at the time of writing this has not yet happened.[3]

HIV patients come from all walks of life, and treatment can be challenging in those from deprived backgrounds. Homelessness, mental illness, substance abuse, and hepatitis C infection can serve as barriers to effective treatment.

A study conducted to see how pharmacist monitoring and intervention could influence outcome found that it improved both adherence and outcomes. Pharmacists were effective in addressing problems due to adverse effects, drug interactions, drugs indicated for comorbidities, adherence issues, drugs no longer indicated and dosage adjustment for weight and renal insufficiency. Individually, the interventions were relatively simple but they significantly improved outcomes for patients.[4]

Current treatment guidelines for HIV recommend combinations of antiretrovirals (ARVs) to achieve optimal suppression of HIV. However, initiation and long-term management in patients is often complicated by variable medication adherence, and complex combinations of medications with multiple drug interactions, drug toxicity, and drug therapy for comorbid conditions that require additional patient education and laboratory monitoring.

For these reasons, multidisciplinary health system management strategies are increasingly including specially-trained pharmacists. Further, the use of fixed-dose ARVs is accompanied by considerable inter-patient variation in pharmacokinetics, which results in a wide range of patient drug exposures from any given ARV dose. One approach to overcoming this variable drug exposure is to use TDM as a clinical tool to adjust doses to achieve targeted concentration ranges, often in conjunction with HIV resistance tests.[5]

HIV is a retrovirus that attacks the body's immune system by breaking down DNA and then reassembling it in order to make copies of itself. Its treatment is challenging because it can rapidly mutate into new strains.

TDM is required in certain antiretroviral medicines, particularly the protease inhibitors and non-nucleoside reverse transcriptase inhibitor categories of ARVs.

A key feature of TDM in antiretroviral treatment compared with other areas of medicine is that multiple agents are concomitantly used to treat HIV, and inadequate concentrations resulting from poor adherence results in the virus evolving mutations, which can limit drug choice.[6]

Protease inhibitors When HIV infects a cell, the cell is programmed to make new HIV genetic material and HIV proteins. These large proteins are broken down by the HIV protease enzyme to create new functional HIV particles.

Protease inhibitors (PIs) block this enzyme and so stop the source of raw material from producing new viruses; they should be used in combination with at least two other HIV drugs for treatment.

Examples of PIs include saquinavir, ritonavir, indinavir, nelfinavir and amprenavir.[7]

TDM of PIs mainly revolves around reducing the risk of side effects by individualising the dosage regimen, guided by plasma level monitoring, without increasing the risk of treatment failure due to suboptimal systemic exposure.

Ritonavir Ritonavir is used to treat HIV-infected patients in combination with other antiretroviral agents.

In adults, the dose is 600mg twice daily, preferably with food. The dose should be gradually increased to achieve the target concentration range for that individual, which is set by the HIV multi-disciplinary team.

Dose adjustments are required in certain patient groups, including:

- those with haematological adverse reactions, such as falling white blood counts or anaemia
- the elderly
- patients with renal implants or hepatic impairment.

The minimum target trough concentration is 2.1mg/ml, half life is 1.1 hours, the clearance rate is 27.1ml/min/kg and the volume of distribution is 1.6l/kg.

Distribution can play a significant role in TDM; the protein binding of ritonavir in human plasma is approximately 98-99 per cent and is constant over the concentration range of 1.0-100µg/ml.

Ritonavir is primarily metabolised by the liver. There are several contraindications and interactions, and these can be found in the SPC.[8]

Anti-cancer drugs and DMARDs

Although anticancer medicines have narrow therapeutic indices, routine TDM is not generally conducted due to the lack of an established relationship between concentration and desired effect. However, methotrexate is an exception to this rule.

Folic acid rescue is essential in methotrexate therapy, but can only be started after serum concentrations fall below 0.05mmol/l, which takes place after one to two days.[9]

In anticancer medicines that target enzymes (eg mercaptopurine, fluorouracil) it is easier to monitor the enzyme responsible than to use TDM.

Methotrexate Before beginning methotrexate therapy, a chest x-ray, examination of lymph nodes, assessment of renal function, liver function and blood elements should be made, as well as history-taking, physical examination and laboratory tests.

These tests should be repeated weekly until therapy is stabilised; from this point patients should be monitored every two to three months throughout treatment. Patients should report all signs and symptoms suggestive of infection, especially sore throat.

In adults with rheumatoid arthritis who have little benefit from conventional therapy, methotrexate can be used. A dose of 7.5mg orally once weekly is used. The weekly dose can be adjusted gradually to achieve an optimal response, but should not be increased beyond 20mg per week.

In elderly patients caution should be exercised and the dose may need to be reduced.

In treating severe psoriasis, 10-25mg orally once weekly, is recommended.

In the UK there has been a number of cases associated with oral methotrexate that have resulted in serious harm or death as a result of inappropriate prescribing, dispensing, administering or monitoring incidents, and the NPSA has issued patient safety alerts providing guidance on how to reduce risk of patient harm associated with incorrect dosing frequency of oral methotrexate.[9]

Before starting cancer therapy a test dose of 5-10mg administered parenterally is given a week prior to the start of full therapy in order to detect idiosyncratic adverse events.

Full treatment then begins with single doses not exceeding 30mg/m^2 on not more than five consecutive days. A two-week period of rest is recommended between treatments to allow the bone marrow recovery.

Doses above 100mg are usually given parenterally. Doses in excess of 70mg/m^2 should not be administered without leucovorin rescue (folinic acid rescue) or assay of serum methotrexate levels 24 to 48 hours after dosing.

If methotrexate is administered in combination chemotherapy regimens, the dose should be reduced taking into consideration any overlapping toxicity of the other drug components.

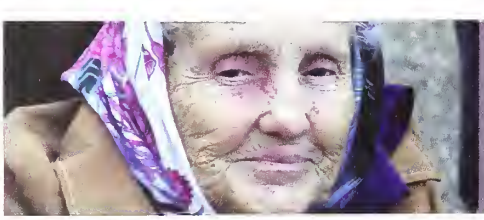
The elimination of methotrexate from plasma should be monitored if possible, particularly when high doses are administered in order to permit calculation of an adequate dose of leucovorin (folinic acid) rescue. Methotrexate has several contraindications, adverse effects and interactions.[10]

Ciclosporin Ciclosporin is also used as a DMARD but long-term data concerning its use is limited. Maintenance treatment is titrated individually according to tolerability, and patients should be re-evaluated after six months. Therapy is only continued if the benefits outweigh risks.

References are available in the full version of this article online at www.chemistanddruggist.co.uk/update.

Ravina Tasgaonkar MRPharmS is a locum community pharmacist and part-time lecturer at the University of Portsmouth

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online (See details on p22).



NEXT WEEK
The first of our two-part series on dementia looks at symptoms and diagnosis

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Release your inner OOMPH

Therapeutic drug monitoring: part 3

How does ciclosporin work? Why is TDM important in antiretroviral treatment? What assessments should be made before starting methotrexate therapy?

This article describes the use of TDM in transplant patients, autoimmune disease, HIV infection, cancer and rheumatoid arthritis. It includes information about ciclosporin, methotrexate, HIV infection and antiretrovirals such as ritonavir.

- Revise your knowledge of immunosupressants and the side effects and doses of ciclosporin by reading section 8.2.2 in the BNF.
- Read the MUR tips for transplant drugs on the C+D website at http://tinyurl.com/tdm10.
- Update your knowledge of the drugs used in HIV treatment by reading section 5.3.1 in the BNF.
- Read the MUR tips for HIV on the C+D website at http://tinyurl.com/tdm20. Think about how you could explain the importance of TDM in the treatment of HIV to a patient or carer.
- Read the information about improving compliance with oral methotrexate on the National Patient Safety Agency website at http://tinyurl.com/tdm30.

Are you now familiar with how TDM is used in transplant patients, autoimmune disease, HIV infection, cancer and rheumatoid arthritis. Could you explain to patients about how their medicines work and why monitoring needs to be carried out?

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Practical Approach

Diabetic patients and Ramadan

David Spencer, pharmacist at the Update Pharmacy, receives a phone call from Dr Lauren Olsen, a trainee GP at a local practice to which David provides prescribing advice.

"A diabetic patient has just been in, and reminded me that Ramadan is coming up soon. He asked me what he should do about his medication," Lauren says.

"Is he intending to fast then?" asks David.

"Yes. I told him that from a purely medical point of view it would be better if he didn't, but he says that it's a religious duty and he feels he must. My problem is that I don't really have any experience in that area and we don't appear to have any protocols or guidelines in the practice that I could refer to."

"What's he on?" David asks.

"He's type 1, on insulin."

"Ah, that's a bit more tricky than type 2 patients on hypoglycaemics, but usually fasting is manageable. I'll get some advice together for you."

Lauren continues: "We've got quite a few Muslim patients who have diabetes, mostly type 2. Can you tell me how to advise them?"

"I think the best thing would be for me to draw up some guidance for the practice for patients on all types of anti-diabetic medication. I'll just need to get your boss's approval first."

Questions

1. When does Ramadan start this year?

2. What is the Muslim religious rule about fasting with a medical condition, and why is careful control of medication particularly important at the moment?

3. What is the advice for patients on the following regimens?

a) diet only

b) metformin

c) sulphonylureas

d) thiazolidinediones

e) insulin

Answers

1. August 12.

2. The Koran exempts sick people from fasting, but many Muslims with diabetes may not perceive themselves as sick and are keen to fast. Ramadan is a dawn to dusk fast for 30 days. Its starting date follows the lunar calendar and moves back by 10 days each year. For the next decade it will occur during the summer in the northern hemisphere, so fasting periods will be very long.

3a) Split daily calories over two to three smaller meals during non-fasting interval; eat complex carbohydrates at suhur (pre-dawn meal) and simple carbohydrates at iftar (evening meal); avoid foods high in fat and sugar.

b) Take 2/3 daily dose at iftar, 1/3 at suhur. For m/r once daily formulations: take dose at iftar.

c) Twice daily dosage: reduce dose at suhur to 1/2 normal; once daily dose: take at iftar.

d) No adjustment required.

e) Patients on a basal bolus regimen four times daily should be discouraged from fasting owing to the risks of poor glycaemic control. Others should monitor carbohydrate intake carefully and reduce background insulin by 20 per cent, omitting the midday rapid-acting insulin if their capillary blood glucose concentration is ≤7mmol/l. If higher, they will need to seek specialist advice.

Further reading

Hui E, et al. Management of people with diabetes wanting to fast during Ramadan. BMJ 2010;340:c3053.

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Got an idea for a Practical Approach scenario or like to write one? Email us at: **haveyoursay@chemistanddruggist.co.uk**

10 THINGS YOU NEED TO KNOW ABOUT...

LUTS and OTC tamsulosin

Lower urinary tract symptoms affect up to 30 per cent of men over 65. **Gavin Atkin** explains this summer's Nice guidelines

1 Pharmacists supplying OTC tamsulosin (Flomax) are bound by restrictions and rules laid out by the manufacturer and Nice. A questionnaire must be used to assess the man's symptoms (this may be provided to the patient's GP). Men with urinary retention should be told by the pharmacist to seek immediate medical treatment, and those with pain on urinating, bloody or cloudy urine, fever, incontinence, or for whom OTC tamsulosin is not indicated for any reason, should be told to see their GP. Patients taking OTC tamsulosin regularly should be told to see their GP by six weeks or earlier to confirm that the cause of their symptoms is benign prostatic enlargement, and then every 12 months, in accordance with the guidance on LUTS. Also, men purchasing OTC tamsulosin must be told to consult their GP if the medicine does not relieve symptoms within two weeks.

2 Good communication on LUTS is essential and should be supported by evidence-based, written information tailored to the man's needs. Treatment, care and information must be culturally appropriate and should also be accessible to men with additional needs such as physical, sensory or learning disabilities, or who do not speak or read English. With the patient's agreement, families and carers should be invited to take part in decisions about treatment and care.

3 GPs are told to assess the man's history to identify possible causes of LUTS, and also to review current medication to identify whether it could contribute to the problem. They should also examine the abdomen and external genitalia, and perform a digital rectal examination (DRE). The patient will be asked to complete a urinary frequency volume chart. Men should be referred for specialist assessment if they have LUTS complicated by recurrent urinary tract infection, retention, renal impairment suspected to be caused by lower urinary tract dysfunction, or suspected urological cancer.

4 Men with storage LUTS (particularly urinary incontinence) should be offered conservative management – a choice of incontinence pads or collecting devices – until a diagnosis and management plan have been discussed. Those suspected of having overactive bladder (OAB) may be given bladder training and advice on fluid intake and containment products if necessary.

5 Surgical treatments offered for voiding LUTS include transurethral resection of the prostate (TURP), monopolar transurethral vaporisation of the prostate (TUVP) or holmium laser enucleation of the prostate (HoLEP).

6 Doctors are required to ensure patients are advised on accessing help with emotional and psychological, sexual and social issues, and given advice about obtaining incontinence products and relevant support groups.

7 Drug treatment should be offered only to men with bothersome LUTS when conservative management options have been unsuccessful or are not appropriate. Comorbidities and current treatment should be taken into account. Drugs that may be offered to men with moderate to severe LUTS are the alpha blockers alfuzosin, doxazosin, tamsulosin and terazosin; an anticholinergic may be offered to men to manage the symptoms of overactive bladder.

8 Treatment with a 5-alpha reductase inhibitor should be considered in men with prostates estimated to be larger than 30g, or a PSA (prostate-specific antigen) level greater than 1.4ng/ml, and in those at high risk of progression, possibly because of age. Men with bothersome moderate to severe LUTS and prostates over 30g or a PSA level greater than 1.4ng/ml may be considered for a combination of an alpha blocker and a 5-alpha reductase inhibitor. Treatment with an anticholinergic as well as an alpha blocker may be considered in men who continue to have storage symptoms after treatment with an alpha blocker alone. Other treatments that can be considered are a late afternoon loop diuretic. This use is unlicensed, so informed consent must be obtained and serum sodium should be measured three days after the first dose. If serum sodium is reduced to below the normal range, desmopressin treatment should be stopped. Oral desmopressin may be used in men with nocturnal polyuria. Homeopathy, phytotherapy and acupuncture should not be offered for treating LUTS in men.

9 The options of active surveillance (reassurance and lifestyle advice without immediate treatment and with regular follow-up) and active intervention (conservative management, drug treatment or surgery) should be discussed with patients with mild or moderately bothersome LUTS, and in men whose LUTS fail to respond to drug treatment.

10 Patients taking drug treatments should be reviewed for the effect of the drugs on the patient's quality of life and to discuss any adverse effects. Specifically, men taking alpha blockers should be reviewed at four to six weeks and then every six to 12 months. Men taking 5-alpha reductase inhibitors should be reviewed at three to six months and then every six to 12 months. Those taking anticholinergics should be reviewed every four to six weeks until symptoms are stable, and then every six to 12 months.

References 1. Over-the-counter tamsulosin: information for pharmacists Nice, June 2010, http://tinyurl.com/tamsulosinguidance 2. CG97 Lower urinary tract symptoms, Nice, May 2010, http://guidance.nice.org.uk/CG97

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on LUTS and OTC tamsulosin

REFLECT	Do I understand the latest guidance for LUTS and OTC tamsulosin?
PLAN	Read this article to revise topics and identify knowlege gaps.
ACT	Read relevant sections of Nice guidelines and implement.
EVALUATE	Am I better able to advise patients about LUTS and OTC tamsulosin?

Why is good pharmacy design so important?

In the first instance, good design is about getting people into your store, pharmacy or otherwise. "The days of pile it high and sell it cheap are long gone," says Robert Hudson, director of the National Association of Shopfitters. "Retailers need to create an experience for the shopper to entice them through the door."

And then it's about getting them buying, as it is in any environment where you are trying to sell services or products. "From hotels to hospitals, people respond favourably to clean, efficient and attractive environments," explains Anderson Retail Consultants' Keith Anderson, "so using good design to enhance the image and functionality of a pharmacy is simply improving your product."

More specifically, says retail designer Paul Garrison, good design maximises the use of space and customer flow. It will also "future-proof" the pharmacy by understanding the changes happening in the sector, such as robotics and requirements for consultation rooms. Mr Garrison of the SGi Group, which has worked with pharmacy companies including Boots and the Co-operative Pharmacy, adds that for independents good design is "critical in them establishing their personality and setting them apart from the big players".

John Hilditch, managing director of specialist retail designer and shopfitter Dollar Rae, agrees: "In challenging times and in an increasingly crowded marketplace, any pharmacy which clearly expresses and communicates the individuality and focus of its business with the right image and right presentation is at a distinct advantage."

Healthcentre contract developer MedicX Pharmacy has a strong focus on design and aims for a hotel-like look rather than the traditional style of the high street pharmacy

Better by design

What to consider when planning a fitout or refit – **Jennifer Richardson** reports

What makes good design?

Where pharmacy design differs from other stores is the retail versus dispensary split, says Mr Garrison, and because most pharmacies make the majority of their money from the latter, good pharmacy design should "always start with where the dispensary goes". It should then consider the type of dispensing and services the pharmacy offers; for example, does it need a methadone area? How many consultation rooms does it need? The final step, says Mr Garrison, is to work on the retail space.

As well as the importance of good pharmacy design outlined above, BAPTT UK sales design director Matthew Jones says it should also:

- increase dispensing workflow efficiency and productivity
- increase dispensing accuracy and safety
- improve patient confidentiality
- ensure compliance with the pharmacy contract, PCT requirements and other regulations such as health and safety
- improve staff morale.

What is the role of a good pharmacy designer/shopfitter?

Broadly, says Mr Anderson, the designer's role is to collect information, identify a design brief, design the best solution within the budget and communicate the concept to the shopfitter, whose role is to accurately and efficiently implement the designer's concept to the highest standards.

A good designer or shopfitter will start by listening to the retailer, says Mr Garrison: "The retailer knows the most about their customers." However, he adds, a good designer or shopfitter will also challenge the retailer. "A good design is often ruined by the retailer adding 'just one more' gondola," Mr Garrison warns.

As well as design principles, a good pharmacy designer or shopfitter will have understanding of the following, adds Mr Jones:

- the brief
- the budget
- local social demographics
- the business's brand
- dispensing processes
- pharmacy legislation.

What should you look for when choosing a shopfitter/designer?

"Recommendation is always going to be the best way of finding a contractor," says Mr Garrison, who also advises pharmacists to ask potential shopfitters for addresses of previous projects in their area for them to visit.

It's also important to consider whether you get on with them, says Mr Jones: "Shopfitting can be stressful – it is very important clear communicatio and a good working relationship is developed." Also look for the following, suggests Mr Jones:

- a proven track record in pharmacy design
- project management experience
- financial stability
- professional accreditations.

Mr Hudson notes that the recently published BSI Shopfitting Management Standard gives, for the first time, a checklist on what you can expect from your chosen shopfitter.

See what makes great pharmacy design
www.chemistanddruggist.co.uk/pda2010

2 important things to take into account in pharmacy design

Floor planning

Floor planning is the "forgotten child of the retail design process", according to Shopsworks managing director Craig Phillipson. "Making floor space work as hard as possible in a retail outlet can often be overlooked in the desire to create a visually stunning masterpiece," he warns, "but if you don't get customers within 1.2 metres of the product or service, they won't buy it."

Use of colour

Colour has a powerful effect on mood and behaviour, says Colour Affects' Angela Wright. "It is the first thing people instinctively look for to give information about anything that confronts us," the colour psychologist explains, "so negative colour schemes will have negative results almost unconsciously, within moments of entering.

"Colour has to be used effectively. Grey is likely to discourage people from spending; red is really the best colour to put out front; and green is most effective in the realm of retail."

How can you get the most out of designers/shopfitters?

The two ts: trust and time. Explains Mr Garrison: "The clients that get the best out of their shopfitters have built up a relationship where they trust each other.

"The more I know up front about what the client wants to achieve and what they want to spend, then the easier the project becomes as I tailor the design from the beginning. The more time we invest in this process, the better the finished product."

You will also need to consider and provide information on the following, says Mr Jones:

- prescription volume and mix
- staff mix and future recruitment plans
- current and planned enhanced services such as supervised methadone
- retail turnover and department breakdown
- local social demographics
- specialist retail requirements, eg fragrances
- number of dispensary computers
- budget
- local competition. ►►

Expert view

"We know that design can positively impact customers' behaviour in a retail environment. In pharmacies, where they offer an increasingly complicated range of products and services, good design can help customers access what they're looking for quickly, helping businesses to prosper. By using clever store layout, signage, lighting and planning, the design of healthcare retail environments can likewise help to reduce opportunities for crimes like theft, burglary and antisocial behaviour."
Mat Hunter, chief design officer, Design Council

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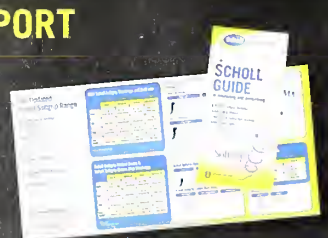

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KEEPING BRITAIN ON ITS FEET

How the multiples are tackling pharmacy design challenges

Lloydspharmacy

Lloydspharmacy has an in-house design team, a situation senior pharmacy designer Darren Cotton says allows the company to have "greater control" over its needs and aims. The need to free up pharmacists' time to get out from behind the dispensary and interact with customers is, he says, driving Lloydspharmacy's current designs, and staff do get "quite a lot of input" into design developments.

The team's recent successes include the merger of two Epping branches to combine high-end retail and services, which gained a highly commended accolade in C+D's 2010 Platinum Design Awards in association with Ceuta Healthcare. Lloydspharmacy is looking to develop this "premium offering", which has so far also included the fitout of the chain's Selfridges London branch (pictured left). Says Mr Cotton: "We're currently looking for new locations to roll that out into."

Rowlands Pharmacy

Rowlands Pharmacy says shop design is an essential part of its strategy to grow its reputation as the 'go-to' destination for health matters, and this is reflected in its new branding, concept store and merchandising strategy.

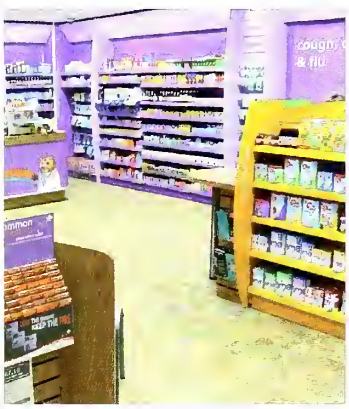
The new concept dispensary is designed to reinforce the message that Rowlands pharmacists are always available to talk to, and to reduce the physical barrier between staff and patients. Consultation areas are fully integrated into the design, and the clean, modern style of the concept reinforces the clinical role of the pharmacist.

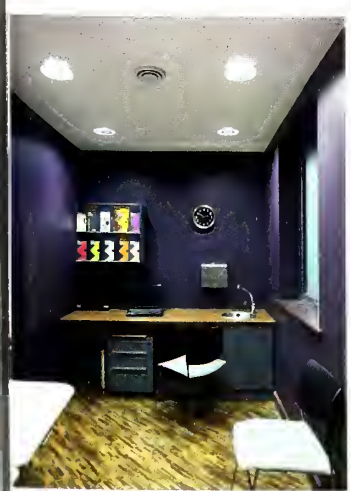
Rowlands has also transformed its front of store layout and merchandising (pictured right). Presenting products by health complaint – such as stomach problems, hay fever and pain control – has made it easier for customers to find what they are looking for and also enables Rowlands to provide more relevant health and self-care information on the shelf.

The new approach has now been rolled out across 36 stores and surveys show it has been well-received by both customers and staff, says managing director Kenny Black. "Customers feel more comfortable and find it easier to seek information and advice about health and medicines. The new stores are reinforcing perceptions that we provide services that go well beyond dispensing.

"Staff understand the critical role the new concept stores are going to play in the future of our pharmacy business and feel supported to give advice and deliver new services."

Rowlands' concept store programme will continue its roll-out over the next few years.





MedicX Pharmacy

MedicX Pharmacy is a developer of healthcentre pharmacies with a strong focus on design. Recent projects include its Blackpool branch (pictured left), which gained a highly commended plaudit in C+D's 2010 Platinum Design Awards in association with Ceuta Healthcare.

MedicX pharmacy director Steve Jeffers says the company aims for hotel-like design, rather than that of a traditional high street pharmacy. For example, they have turned the medicines counter into a "reception desk", without clutter, "so that people view us in a different light". And their pharmacies have a confidential pick-up area, with a proper work bench so that, if necessary, the pharmacist can take items out of the prescription bag and discuss them with the patient.

MedicX Pharmacy is currently working on the next generation of consultation rooms for its pharmacies, to take into account issues such as infection control procedures.

Case study

The Co-operative Pharmacy Lowe House Health Centre, St Helens

In February 2010, Lowe House Health Centre opened its doors to 21,000 local residents, bringing together four GP practices and giving the Co-operative Pharmacy the opportunity to relocate from a Victorian terrace building.

The space was much larger than usual for a medical centre, enabling an extensive range of services, including an asthma clinic and weight management as well as a chiropractor, podiatrist and audiology, to be provided under one roof.

Input from various teams within the business was crucial in the planning stages. This included contributions from the superintendent pharmacist, healthcare services and OTC teams, regional operations team and marketing. External design input was provided for optimum space.

Comfort in the waiting room and reducing queue times were key objectives. The waiting area is located between the two entrances/exits and is circular, creating a feeling of space, with seating for 18. Wall-mounted television screens in the centre of this area are pivotal to the queue management system, alerting people to pick up their medication when ready.

Two consultation rooms, one treatment room and a methadone dispensing area ensure privacy for patients. There is also a dedicated prescription storage area.

Ensuring there was enough room in the dispensary to maximise efficiency, enable staff to work comfortably and to promote best practice and safe dispensing were key priorities in the pharmacy's design.

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on pharmacy design

REFLECT	Does my pharmacy present a professional image and support work processes?
PLAN	Consider how a refit or smaller layout changes could improve image and work processes
ACT	Implement refit or layout changes
EVALUATE	Have public image and workflow improved?

Coming up

See the best of the best in pharmacy design over the coming months, with our coverage of the winners of the C+D Platinum Design Awards 2010 in association with Ceuta Healthcare
PLUS more refit tips from the experts.
Next week: third prize winner Primary Care Pharmacy, Nuneaton
PLUS eight design tips for retail success.

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CAREERS

steps to switching off on holiday

Psychology expert professor Cary Cooper offers his top tips on leaving work behind when you go away – **Hannah Flynn** reports

1.Lay some ground rules before you leave

Realistically, any pharmacist going on holiday will have a locum covering them while they are away.

Pharmacy owners will have organised cover for the other aspects of their role, says Cary Cooper, professor of organisational psychology and health at Lancaster University Management School. It helps if you use a locum you know and trust with your pharmacy.

However, professor Cooper acknowledges that, even with everything in place, things will go wrong. Therefore you must put some ground rules in place before you go.

"Whoever is taking over must not call you unless there is a real emergency," he says.

You must outline to all of your staff what constitutes a "real emergency" before you go.

The big switch off: have a no email and no mobile rule when on holiday

2. Don't take your phone or laptop

"Instigate a no email and no mobile rule for your holiday," professor Cooper advises.

"If you log into your emails and see that something has gone wrong it may upset you."

Professor Cooper says many people find it hard to switch off when they have their laptop or mobile phone with them.

He suggests considering whether there is any real need for taking either of them, or if there will be facilities available where you are going that will allow you to get in touch in the event of an emergency.

3. Take at least two weeks off

Professor Cooper advises it will take at least two days to wind down once you have arrived at your destination, so if you spend a day travelling either way on a one week holiday you will only have three days to relax.

"Take a reasonable length of time off, at least 10 days. You want to maximise the amount of time you have to just enjoy your holiday," he says.

Of course, your ability to do this will depend on how many days holiday a year you are entitled to and able to take off.

But, instead of spreading out holidays thinly, try to ensure you have at least one two-week break a year so you can make sure you have time to switch off.

4. Spend time with your family

You need to make sure you make the most of your time away from work, and devote time to the people you don't get to spend time with during your working week.

If you are with your family make sure you spend as much time with them as possible, and if you are with your partner make sure the two of you do as much together as possible.

Professor Cooper says spending time with your group means there is little time to get distracted and think about work.

5. Don't dwell by the pool

"It is very important to keep active so you can keep your mind off work," says professor Cooper.

He suggests limiting time spent by the pool, as lingering there could allow your mind to wander. Instead, he suggests keeping as active as possible. "If you just lie by the pool being sedentary then this makes you think about things.

"I am not saying don't take some books to read, but make sure your rest time is spent around and with other people.

"Do things that will make you take your mind off work."

Activities professor Cooper suggests doing include walking and exploring the area you are in. Check out what other activities are available before you go, too.

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on work pressures

REFLECT	Do I cope well with work pressures?
PLAN	Consider what mechanisms I can put in place to help me cope, including methods to help me switch off on holiday
ACT	Implement identified mechanisms
EVALUATE	Am I better able to cope with work pressures and has this improved the service I am able to offer?

Need career advice? Ask us, we'll find out.

jennifer.richardson@ubm.com

How do you switch off on holiday?

"I get myself involved with all the sights and places I am going to see and make sure I tell myself to try to not think about work."
Aina Osunkunle, K and A Pharmacy, Gateshead

"When you are on holiday you need to make sure people know not to contact you and that helps to switch off."
Amish Patel, Hodgson Pharmacy, Dartford

"Normally I do something that involves an adrenaline rush, like scuba diving or skiing, to keep my mind off work. Anything like that helps."
Nicola Passmore, Manor Pharmacy, Newark

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Postscript...

Charity summer bonanza – part two

A few weeks ago Postscript promised a second round-up of the great work pharmacists are doing for charity – and here it is.

First up is Jon Porteous, former owner of Studley Pharmacy in Warwickshire, who cycled his way from Land's End to John O'Groats to raise money for charity Beating Bowel Cancer. Jon drummed up an impressive £1,000 on his 924-mile challenge, which was dedicated to the memory of pharmacist Lucie Litchfield, who died from bowel cancer in 2008 aged 25.

And congratulations to Rowlands Pharmacy, which has raised more than £150,000 for the NSPCC and ChildLine over five years of fundraising, such as managing director Kenny Black dressing up as Elvis (pictured, right, with marketing manager Mike Johnson). The multiples' efforts, which have included marathons, sweepstakes, and a World Cup table football competition, have led to the chain being designated a patron by the NSPCC.

Last but not least comes Prestwood Pharmacy in Buckinghamshire, which held a tea party to raise money for Marie Curie Cancer Care last month. The tea party, which included a raffle, tombola and donated tea and cakes, raised more than £500 for the charity. Well done!

Have you been raising money for worthy causes? Email postscript@chemistanddruggist.co.uk and let us know what you've been up to.

C+D reader of the week

Meet Kenley Brown of Tims and Parker in Walkden, Manchester, and find out where he thinks pharmacy is going.

What attracted you to working in pharmacy?
My favourite subject at school was science, and I wanted to work in a role that involved helping the public.

If you weren't a pharmacist, what would you be?
I think I would have been a doctor, as again it involves helping the public and requires a love of science.

What is your favourite holiday destination?
It has to be Jamaica in the Caribbean. It is a fabulous place, and also where I was born. I have not been since 1996, to see family, so I think that I am well overdue a visit!

What are your hobbies?
I enjoy cricket, gardening and the occasional spot of DIY.

What would you say is the most rewarding aspect of your job?
I enjoy helping people to improve their health, and it is great when you witness a noticeable difference in the wellbeing of a patient.

What makes you laugh?
I like comedy shows, especially by witty comedians. One of my all-time favourites is Dave Allen, who had such a perceptive humour.

How do you see pharmacy changing in the next five years?
I think that there will be much more reviewing services, such as MURs, so that we can use our pharmaceutical knowledge for the benefit of patients.

Calling all pharmacists and technicians. We want you to be our reader of the week. Email us at postscript@chemistanddruggist.co.uk

The Victorian Pharmacist

"POOR APHRODITE HAS BEEN MADE TO DON AS MANY AS POSSIBLE OF THE APPLIANCES, IN MINIATURE"

Sir,
Anyone interested in the study of that phase of London life embracing the art and mystery of physicking the working classes cannot do better than, on any fine Saturday evening, taking a stroll down the Mile End Road. From religion and the physical sciences to hokey-pokey and bootlaces downwards, all wants are here supplied at the smallest possible outlay.

Here the intelligent and appreciative observer may stop to gaze at a herbalist's window, the most striking feature of which is a plaster cast of Venus of Medici. Yet poor Aphrodite has been made to don as many as possible of the surgical appliances, in miniature, that have been invented to counteract the evils the flesh is heir to. The splendid proportions of the human form divine are in this instance embellished by such monstrous encumbrances as an abdominal belt, a double truss, elastic stocking on one leg, a knee-cap on the other, and a lung-protector.

On the kerb, just opposite this temple of Venus, some elderly gentlemen, exhibiting a phenomenous darkening around his left eye, is holding forth on the medicinal virtues of his "Torquay rhubarb". Nearby dealers in corn and wart remedies, of course, abound; their stock of mysterious-looking compounds is generally of the most portable description, and of course are all infallible, with numerous testimonies to support their use. I could go on. Clearly we have a duty to bring modern healthcare to all in the metropolis, and wash this quackery from the streets.

The Victorian Pharmacist's comments come from a lively description of the Mile End Road from C+D in 1884, where street vendors plying quack cures were rife.

Where is the pharmacy industry going?

Tricky question. Simple answer.

Just about anyone who is anyone in the pharmacy business is gathering at The Pharmacy Show this October. There will be more than 220 leading suppliers (the most ever), over 50 world class conference speakers, senior executives, leading regulators, top policy-makers, all the major associations and most importantly of all your industry peers, people just like you… thousands of frontline pharmacists, pharmacy executives, owners and support staff. There's plenty to talk (and learn) about. Whether it's the new frontline healthcare responsibilities facing community pharmacies, strategies and tactics for trading through challenging times or the need to source profitable new retailing ideas, you can get it all at the UK's largest source of world-class, live CPD education and the biggest sourcing event for medicines, equipment, technology, retail and services. And, remarkably, it's all **FREE**.

Go to **www.thepharmacyshow.co.uk** for the full programme and to get your free delegate pass. Or call **01926 485151**

Pharmacy Show

10th – 11th October 2010 / The NEC Birmingham

Pictured L to R: Bernard Mweseka, Pharmacy Manager, Day Lewis; Dvyesh Patel, Pharmacy Technician, MED-Chem Pharmacy; James Davies, Academic Pharmacist, London School of Pharmacy; Mike Ritson, Superintendent, ABC Drugstores; Richard Harrild, Retail Sales Manager, Lloydspharmacy; Raj Bali, Pharmacist, Lloydspharmacy; Ali Gul Ozbek, Owner-Superintendent, MED-Chem Pharmacy.

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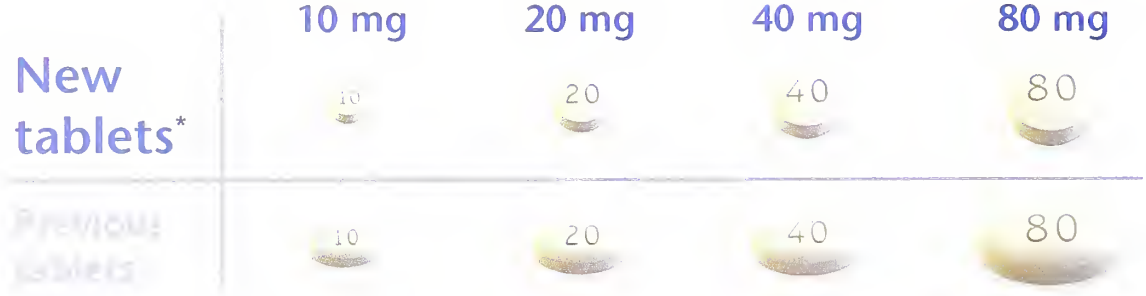

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Abbreviated prescribing information: Lipitor®
Presentation: Lipitor is supplied as film-coated tablets containing 10mg, 20mg, 40mg or 80mg of atorvastatin.
Indications: In patients unresponsive to diet and other non-pharmacological measures, Lipitor is indicated for the reduction of elevated total cholesterol, LDL-cholesterol, apolipoprotein B, and triglycerides in adults and children aged 10 years and older with primary hypercholesterolaemia, heterozygous familial hypercholesterolaemia or combined (mixed) hyperlipidaemia. Lipitor also raises HDL-cholesterol and lowers the LDL/HDL and total cholesterol/HDL ratios. Lipitor is also indicated for the reduction of elevated total cholesterol, LDL-cholesterol, and apolipoprotein B in patients with homozygous familial hypercholesterolaemia. Lipitor is indicated for reducing the risk of cardiovascular events in patients with Type II diabetes and one additional risk factor, without clinically evident coronary heart disease, irrespective of whether cholesterol is raised.
Dosage: The usual starting dose is one Lipitor 10mg tablet daily. Doses should be individualised according to baseline LDL-C levels, the goal of therapy, and patient response. Doses may be given at any time of the day with or without food. The maximum daily dose is 80mg. For patients taking drugs that increase plasma exposure to atorvastatin the starting dose should not exceed 10 mg and maximum dose of less than 80 mg may have to be considered. Doses above 20mg/day have not been investigated in patients aged <18 years. In primary prevention trials, the dose was 10mg/day.
Contraindications: Hypersensitivity to any of the ingredients, active liver disease, unexplained elevations in serum transaminases, pregnancy and breast-feeding and in women of child-bearing potential not using contraception.
Warning and precautions: Liver function tests should be performed before initiation and periodically thereafter and in patients who show signs and symptoms of liver injury (monitor raised transaminases until they return to normal). Drug dosage should be reduced or therapy discontinued if persistent elevations occur above 3-times the upper limit of normal. Lipitor should be used with caution in patients with a history of liver disease and/or alcoholism. For patients with prior haemorrhagic stroke or lacunar infarct, the balance of risks and benefits of atorvastatin 80 mg is uncertain and the potential risk of haemorrhagic stroke should be carefully considered before initiating treatment. Patients with signs and symptoms of myopathy should have their creatine phosphokinase (CPK) levels monitored. Lipitor should be discontinued if CPK levels are markedly or persistently raised or myopathy is diagnosed or suspected. Lipitor should be prescribed with caution in patients with pre-disposing factors for rhabdomyolysis. Risk of myopathy may increase when administered with certain medications that increase the plasma concentration of atorvastatin. If co-administration is required a dose reduction or if not practical a temporary suspension should be considered; the starting dose of atorvastatin should be 10 mg. In the case of ciclosporin, clarithromycin and itraconazole a lower maximum dose should be used. Although interaction studies with atorvastatin and fusidic acid have not been conducted, severe muscle problems such as rhabdomyolysis have been reported in post-marketing experience with this combination – therefore patients should be closely monitored and temporary suspension of atorvastatin treatment may be appropriate. As with other statins, rhabdomyolysis with acute renal failure has been reported. A history of renal impairment may be a risk factor for rhabdomyolysis. Exceptional cases of interstitial lung disease have been reported with some statins and statin therapy should be discontinued if a patient is suspected to have developed interstitial lung disease. Patients with galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption should not take this product.
Pregnancy and lactation: Lipitor is contraindicated in pregnancy and lactation.
Side effects: Side effects most frequently reported in controlled clinical studies: nasopharyngitis, hyperglycaemia, pharyngolaryngeal pain, epistaxis, constipation, flatulence, dyspepsia, abdominal pain, headache, nausea, arthralgia, myalgia, pain in extremity, musculoskeletal pain, muscle spasms, joint swelling, asthenia, diarrhoea, insomnia, abnormal liver function tests, elevations in ALT and CPK levels. Other side effects have been reported in clinical trials and post-marketing (See Summary of Product Characteristics).
Legal category: POM.
Date of Revision: December 2009
Package quantities, marketing authorisation numbers and basic NHS price: Lipitor 10mg (28 tablets), PL16051/0001 £13.00, Lipitor 20mg (28 tablets), PL16051/0002 £24.64, Lipitor 40mg (28 tablets) PL16051/0003 £24.64, Lipitor 80mg (28 tablets) PL 16051/0005 £28.21.
Marketing Authorisation Holder: Pfizer Ireland Pharmaceuticals, Pottery Road, Dun Laoghaire, Co. Dublin, Ireland.
Lipitor is a registered trade mark.
Further information is available on request from: Medical Information, Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS.
Ref: LR 12_1.

Reference: 1. Colhoun HM *et al. Lancet* 2004; **364**: 685-696.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk Adverse events should also be reported to Pfizer Medical Information on 01304 616161.

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